Health Care and Dependent Care

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA you do not pay federal or FICA (Social Security) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

King County offers two types of FSAs:

- **Health Care FSAs** allow you to set aside pretax dollars to pay for certain expenses not covered by your health plans (for example, the cost of orthodontia not fully paid by your dental plan and copays for office visits).
- **Dependent Care FSAs** allow you to set aside pretax dollars to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent while you and your spouse work.

This guide explains how FSAs work and includes an FSA Enrollment Form on the last page. If you decide to enroll, return the form to Benefits & Well-Being:

- Within 30 days of your benefit eligibility date if you're a new employee
- Within 60 days of a qualifying status change if you're an established employee enrolling for the first time (see "Making Changes" sections for examples of qualifying status changes)
- By the open enrollment deadline if you wish to enroll or re-enroll for next year (you must re-enroll each year to continue participating in FSAs).

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and the contracts or other legal documents, the legal documents will always govern. King County intends to continue these plans indefinitely but reserves the right to amend or terminate them at any time, for any reason, according to the amendment procedures described in the legal documents. This booklet does not create a contract of employment between King County and any employee.

✝ Table of Contents

✝ Administrative Facts

The following is plan information you might need when dealing with benefit claims and questions.

Plan Name	Health Care Flexible Spending Account (also known as Health Care Personal Choice Account®) Dependent Care Flexible Spending Account (also known as Dependent Care Personal Choice Account®)
Plan Year	January 1 – December 31
Plan Sponsor	If you have questions about FSA **eligibility** or **enrollment**, contact Benefits & Well-Being. Information, including copies of this guide and FSA forms, is also available at www.metrokc.gov/ohrm/benefits. **King County Benefits & Well-Being** Yesler Building YES-HR-0500 400 Yesler Way, Seattle WA 98104-2683 Phone 206.684.1556 ✍ Fax 206.684.1925 kc.benefits@metrokc.gov ✍ www.metrokc.gov/ohrm/benefits
Type of Administration	The FSA Plan is administered for King County according to the terms of an agreement with Associated Administrators Inc. Contact AAI if you have questions about **eligible expenses** or **reimbursement.** **AAI** PO Box 3199 Portland OR 97208-3199 Phone 1.800.334.4340 ✍ Fax 1.800.979.8987 flex@aai-tpa.com
Plan Funding	Plan benefits are funded through employee before-tax salary reduction contributions, as permitted by Internal Revenue Code Section 125.
Plan Expenses	In general, King County pays the administrative expenses of the Plan, to the extent those expenses are not paid from the Plan.

How FSAs Work

Here's how FSAs work:

- You decide how much you want to contribute to either a Health Care or Dependent Care FSA, or both.
- You enroll by completing the form on the last page. It authorizes the county to deduct a certain portion of your salary each pay period on a pretax basis. These contributions are then placed into your account(s) throughout the calendar/plan year via payroll deduction. The accounts are administered for the county by AAI.
- As you incur eligible expenses, you submit reimbursement request forms — plus receipts and/or other documentation — to AAI and AAI reimburses you from your FSA account. Generally, reimbursement requests are processed within 48 hours of receipt by AAI. If the reimbursement is approved, a check is issued or direct deposit transmitted the night your request is processed and an explanation of reimbursement is mailed to your home address.
- You may submit reimbursement requests for expenses incurred during the calendar year any time through March 31 of the following year (requests must be received by AAI no later than March 31), and you may submit multiple bills or receipts with one reimbursement request form.
- Each year during open enrollment you must re-enroll to continue participating and you may change the amount you contribute.

Savings Example

The following example shows how a single person making $35,000 a year can save $334 in income taxes annually by contributing to a Health Care FSA. It uses projected tax rates for 2002 and assumes single filing status. Generally, the higher your tax bracket, the more you can potentially save.

	Without FSA		With FSA		
Annual salary	$ 35,000		$ 35,000		
Pre-tax contribution to FSA	- 0		- 1,200		
W-2 income	$ 35,000		$ 33,800		
Standard deduction	- 4,550		- 4,550		
Personal exemption	- 2,900		- 2,900		
Taxable income	$ 27,550		$ 26,350		
Federal income tax	$ 4,195		$ 3,953		
FICA tax on W-2 income (7.65%)	+ 2,678		+ 2,586		
Total federal taxes	$ 6,873	-	$ 6,539	=	**$ 334 saved**

✝ General Restrictions

Because of the tax advantages available to you, the IRS limits how you can use FSAs and how much you can contribute:

? Under the county plan, the maximum that can be contributed to King County's Health Care FSA is $3,000 per year. The maximum that can be contributed to a Dependent Care FSA is $5,000 per year if married filing a joint return or head of household; $2,500 if married filing separately. The minimum that can be contributed to either FSA is $300 per year.
? Health Care and Dependent Care FSAs are separate. The money you allocate for one cannot be used for the other and you cannot transfer dollars between accounts.
? Expenses for certain eligible services incurred during the calendar year are reimbursed from an FSA. You have until March 31 of the following year to file reimbursement requests (your request must be received by AAI no later than March 31).
? You must use FSA money or you lose it. Any money left in an FSA that cannot be reimbursed is forfeited, so it's important to estimate annual expenses carefully before enrolling and set aside only as much as you expect to spend.
? You cannot use a Health Care FSA to pay expenses you claim as health care deductions on your income tax return.
? Each dollar of dependent care expenses reimbursed through a Dependent Care FSA reduces the amount you can apply toward the federal Dependent Care Tax Credit.

FSA contributions may affect Social Security benefits. Because you and the county don't pay Social Security (FICA) taxes on the money you contribute, your future Social Security benefits may be reduced slightly. However, you may find that the tax savings gained through participation in an FSA outweighs any loss in benefits. Contact your tax advisor for help deciding whether or not FSAs are right for you.

Nondiscrimination testing may affect your contributions. Nondiscrimination testing is conducted to ensure that the plan does not favor highly compensated employees. If King County fails nondiscrimination testing, highly compensated employees may be asked to limit or stop their contributions to the program. For more information contact Benefits & Well-Being.

✝ When You Can Enroll

You can enroll in an FSA:

? Within 30 days of your benefit eligibility date if you're a new employee
? Within 60 days of a qualifying status change if you're an established employee enrolling for the first time (see "Making Changes" sections for examples of qualifying status changes)
? By the open enrollment deadline if you wish to enroll or re-enroll for next year -- you must re-enroll each year at open enrollment to continue participating in FSAs.

To enroll, complete the FSA Enrollment Form (page 21) and return it to Benefits & Well-Being. Include the Reimbursement Direct Deposit Form (page 20) when you enroll if you want your FSA reimbursements direct deposited to your bank account.

Benefits & Well-Being verifies your eligibility and transmits enrollment information to AAI, King County's FSA plan administrator. AAI correspondence may refer to your FSA as a Personal Choice Account®. Don't let the interchangeable terms confuse you -- your AAI Personal Choice Account® is your FSA!

✝ Health Care FSAs

FSA vs. Itemized Tax Deduction

You may use a Health Care FSA to pay for any health care expenses considered tax deductible by the IRS, but you also have the option of taking a federal income tax deduction for health care expenses if your eligible expenses exceed 7.5% of your adjusted gross income (AGI). Your contributions to the Health Care FSA do not count toward reaching the 7.5% AGI threshold. In other words, you may not take a tax deduction for the same expenses that are reimbursed from a Health Care FSA. For most people, the Health Care FSA makes the most sense and offers you significant income tax savings throughout the calendar year. Please see a tax advisor for advice on your personal situation.

Eligible Health Care Expenses

Following is a partial list of health care expenses eligible for reimbursement through a Health Care FSA (if you have questions about expenses not listed, contact AAI):

- Acupuncture
- Ambulance
- Artificial limbs
- Birth control pills
- Braille books and magazines
- Car controls for a disabled person
- Care for a mentally disabled child
- Chiropractor fees
- Christian Science practitioner fees
- Coinsurance/copayments
- Contact lenses and contact cleaning solutions
- Crutches
- Deductibles for medical, dental and vision plans
- Dental fees
- Dentures
- Diagnostic fees
- Disabled person's cost for special home
- Drug addiction treatment
- Eyeglasses
- Eye exams
- Fertility enhancement
- Hearing aids and batteries
- Home improvements for medical reasons
- Hospital bills
- Hypnosis for treatment of an illness
- Insulin
- Laboratory fees
- Laser eye surgery
- Learning disability
- Life fee to retirement home for medical care
- Maternity care
- Medical conferences
- Mileage related specifically to medical condition
- Naturopathic provider fees
- Obstetrical services
- Operations
- Optometrist
- Orthodontics
- Orthopedic shoes
- Oxygen
- Physician fees
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Routine physicals
- Seeing-eye dog and its upkeep
- Skilled nurse fees (including board and Social Security taxes you pay)
- Smoking cessation program's prescribed drugs
- Spa/pool equipment prescribed by physician and allowed by the IRS
- Special schools for mentally impaired or physically disabled person
- Telephone designed for hearing impaired person
- Television audio display equipment for hearing impaired person
- Therapeutic care for drug and alcohol addiction
- Therapy received as medical treatment
- Transportation expenses for medical purposes
- Tuition at special school for disabled person
- Tuition fee portion that goes for medical care
- Vaccines
- Well-baby and well-child care
- Wheelchair
- Wigs required for medical purposes
- X-rays

Ineligible Health Care Expenses

Following is a partial list of health care expenses not eligible for reimbursement through a Health Care FSA (if you have questions about expenses not listed, contact AAI):

- ? Cosmetic surgery or procedures of any kind
- ? Diaper services
- ? Divorce expenses (even if recommended by a physician)
- ? Domestic help fees (for services of a non-medical nature)
- ? General counseling (e.g. family, marital or couple)
- ? Health club memberships
- ? Health insurance premiums
- ? Lens replacement insurance
- ? Long term care expenses
- ? Long term care insurance premiums
- ? Maternity clothes
- ? Nutritional supplements
- ? Over-the-counter drugs, products or formulas (even if prescribed by a physician)
- ? Parking fees
- ? Physical therapy treatments for general well-being
- ? Supplements prescribed by a naturopath or chiropractor (even if the services are covered)
- ? Union dues
- ? Vitamins
- ? Weight-loss programs unless program is undertaken at a physician's direction to treat an existing disease (like heart disease).

Estimating Expenses

The following planning worksheet can help you estimate your eligible health care expenses not covered by your other benefits. Remember, all eligible expenses for you, your spouse and your eligible dependents are reimbursable from your Health Care FSA.

Medical Expenses	Estimated Plan Year Expenses
Copayments	$_____
Deductibles	$_____
Physical exams	$_____
Prescription drugs	$_____
Surgical fees	$_____
X-ray or lab fees	$_____
Other medical expenses	$_____
Dental Expenses	
Copayments	$_____
Deductibles	$_____
Dentures	$_____
Examinations	$_____
Orthodontia	$_____
Restorative work (crowns, caps, bridges)	$_____
Teeth cleaning	$_____
Other dental expenses	$_____
Total Column 1	**$_____**

Vision Expenses	Estimated Plan Year Expenses
Contact lens supplies	$_____
Copayments	$_____
Deductibles	$_____
Eye examinations	$_____
Prescription contact lenses	$_____
Prescription eyeglasses or sunglasses	$_____
Other Expenses	
Acupuncture, chiropractors, naturopaths	$_____
Hearing aids	$_____
Immunization fees	$_____
Psychiatrist, psychologist, counseling (allowed for treatment of specific physical or mental disorder, e.g. depression, alcohol or drug treatment; diagnosis is necessary for reimbursement)	$_____
Total Column 2	**$_____**

Total Column 1 $_____ + Total Column 2 $_____ = Total Estimated Expenses $_____

Making Changes

The election you make when you enroll is effective for the entire calendar year. You may only change your election — begin, increase, decrease or stop your contributions — during open enrollment, or when you have a qualifying status change. The following are examples of qualifying status changes:

- Change in your legal marital status including marriage, divorce, death of a spouse, legal separation or annulment
- Change in the number of your dependents due to birth, adoption or placement for adoption, or death of a dependent
- Ending or starting employment by you, your spouse or dependent
- A reduction or increase in hours by you, your spouse or dependent, including a switch between part-time and full-time status, a strike, lockout or beginning or return from an unpaid leave of absence (including FMLA leave)
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, gain or loss of student status, marriage or any similar circumstances as are provided in the accident or health plan
- Change in the place of residence or work of you, your spouse or dependent
- Significant changes in the health coverage of the employee or spouse attributable to the spouse's employment.

You have 60 days from the date of your status change to change your FSA election(s). The change you make must be consistent with and on account of your status change. For example, if you adopt a child you can begin or increase contributions to a Health Care FSA (that's consistent with the status change), but you cannot stop or reduce contributions to a current FSA (that's not consistent). Questions? Please contact Benefits & Well-Being.

Reimbursement

Copy and use the Health Care Reimbursement Request Form (pages 15-16) to get reimbursed for health care expenses. How you file for reimbursement depends on the type of expense you have — partially covered by health insurance, not covered by health insurance, or orthodontia expenses:

- For expenses partially covered by insurance, file a claim with your health plan. When you receive your Explanation of Benefits (EOB), you will see how much the plan paid and the remaining balance due. You may then request reimbursement to pay for the remaining balance. Complete the reimbursement request form, attach your EOB, then fax or mail the information to AAI.
- For expenses not covered by insurance, complete the reimbursement request form and attach your itemized receipt(s) for the expense. Receipt(s) must show date of service, cost, service performed and provider of service. Cancelled checks, credit card receipts or statements showing only "balance due" or "payment on account" cannot be accepted. Fax or mail the information to AAI.
- For orthodontia services, only the cost incurred during the current calendar year is eligible. For example, if the total cost of orthodontia services is $4,000 and the treatment is expected to take 24 months, only $2,000 is eligible each calendar year. Complete a reimbursement request form and attach a statement from the orthodontic office indicating the dates of service (for example, January 1 through December 31) and the cost of the treatment for the calendar year. Fax or mail the information to AAI.
- For monthly orthodontia expenses, complete a reimbursement request form and attach a receipt or invoice showing payment amount, date of service, a notation that the payment is for orthodontia services, and the provider of services. Fax or mail the information to AAI.

When your Health Care FSA reimbursement request is received and approved, you are reimbursed for your eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year. Even if your reimbursement request is greater than your current account balance, you will be reimbursed for the total amount of your request, up to the total Health Care FSA contribution you elected for the calendar year.

If You Leave Employment

If you leave employment you may continue participating in your Health Care FSA (contributing to the account and requesting reimbursements) through the end of the calendar year as long as you elect to continue the FSA under COBRA. You have until March 31 of the following year to submit reimbursement requests for expenses incurred during the calendar year while under COBRA.

If you leave employment and do not continue your Health Care FSA under COBRA, your participation in your FSA ends the day you leave employment. You have until March 31of the following year to submit reimbursement requests for expenses incurred through the date you leave.

✝ Dependent Care FSAs

How You Qualify

If you work full- or part-time and have children, a disabled spouse, or elderly dependent parents and use dependent care services on a regular basis, you can take advantage of a Dependent Care FSA to help pay for these expenses. To qualify, you must be at work while your eligible dependents receive care. You must also meet one of the following eligibility requirements:

? You are a single parent
? You have a working spouse
? Your spouse is a full-time student at least 5 months during the calendar year while you are working
? Your spouse is mentally or physically unable to care for him/herself
? You are divorced or legally separated and have custody of your child most of the time (even though your former spouse may claim the child for income tax purposes).

Eligible Dependents

Eligible dependents — for the purposes of this plan only — include children, spouse, and dependent parents:

? Your child age 12 or younger of whom you have custody and for whom you are entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, only the parent with custody can consider the child an eligible dependent under this plan.
? Incapacitated parent residing in your household full time.
? Your child of any age who is physically or mentally unable to care for him/herself
? Your spouse who is physically or mentally unable to care for him/herself.

Eligible Dependent Care Expenses

The following types of care are reimbursable from a Dependent Care FSA:

? Care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes, or one of your children under age 19.
? A dependent care center or child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations).
? A housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent.
? Adult care for an incapacitated spouse or parent. This includes only the day care expenses. Nursing/medical care does not qualify for reimbursement through a Dependent Care FSA, but may qualify under a Health Care FSA.
? Expenses for overnight camps are **not** reimbursable.
? Expenses for education (including kindergarten) are generally **not** reimbursable. However, if the cost of tuition and dependent care can be separated, the itemized cost of the dependent care is reimbursable.

To qualify for reimbursement, you must provide your dependent care provider's tax ID number, Social Security number or license number on your federal tax return. If you fail to do so, your Dependent Care FSA reimbursements may be reclassified as taxable income by the IRS. Remember that you are still required to complete IRS Form 2441 when reporting taxes at the end of each calendar year.

You are responsible for making sure the expenses you submit for reimbursement are considered eligible expenses by the IRS. If you're not sure whether an expense is eligible, contact AAI.

Contribution Limits

The minimum you may contribute to a Dependent Care FSA is $300 per calendar year. The maximum you may contribute annually depends on your family situation. If more than one of the following situations applies to you, your maximum contribution will be the lesser of the two:

- If you are a working single parent, you may contribute up to $5,000 per calendar year.
- If you are married and filing a joint income tax return, you may contribute up to $5,000 per calendar year. (If your spouse also has access to a Dependent Care FSA, your combined limit is $5,000).
- If you are married and filing separate income tax returns, you may contribute up to $2,500 per calendar year.
- If you are married and your spouse is a full-time student or disabled (defined by the IRS as physically or mentally incapable of self-care), you may contribute up to $3,000 per calendar year for one dependent, or up to $6,000 per calendar year for two or more dependents.
- If you are married and your spouse earns less than $5,000, you may contribute up to the amount of your spouse's annual income.

FSA vs. Tax Credit

When you file your federal income taxes, you have the option of taking an income tax credit for your dependent care expenses. In some cases, you may be able to take advantage of both the tax credit and the Dependent Care FSA. However, the amount you contribute to your Dependent Care FSA reduces — dollar-for-dollar — the amount of your dependent care tax credit. Please see a tax advisor for advice on your personal situation.

Estimating Tax Credit

The following worksheets and charts can help you estimate and compare income tax savings from the federal Dependent Care Tax Credit with those from a Dependent Care FSA. Tax regulations, however, are complex and these worksheets cannot take all of them into account. You may wish to consult your tax advisor to help you determine which approach is best for your situation.

Worksheet 1: Estimating Income Tax Savings with Federal Dependent Care Tax Credit	
1. Enter your adjusted gross income, including your pay and, if married, your spouse's pay and any other taxable income.	$_____
2. Enter your estimated dependent care expenses ($3,000 maximum for one dependent and $6,000 maximum for two or more dependents).	$_____
3. Enter the federal Dependent Care Tax Credit decimal value from Chart 1 below for your adjusted gross income as shown on line 1 above.	_____
4. Multiply the amount on line 2 by the decimal value on line 3. **This is your estimated income tax savings with the federal Dependent Care Tax Credit.**	$_____

Chart 1

Adjusted Gross Income	Tax Credit Decimal Value	Adjusted Gross Income	Tax Credit Decimal Value
Under $15,000	.35	$29,001 to $31,000	.27
$15,001 to $17,000	.34	$31,001 to $33,000	.26
$17,001 to $19,000	.33	$33,001 to $35,000	.25
$19,001 to $21,000	.32	$35,001 to $37,000	.24
$21,001 to $23,000	.31	$37,001 to $39,000	.23
$23,001 to $25,000	.30	$39,001 to $41,000	.22
$25,001 to $27,000	.29	$41,001 to $43,000	.21
$27,001 to $29,000	.28	Over $43,000	.20

Worksheet 2: Estimating Income Tax Savings with Dependent Care FSA	
1. Enter your adjusted gross income from Worksheet 1, line 1.	$_____
2. Enter the amount of your planned contributions to the Dependent Care FSA (amount cannot exceed $5,000 per calendar year if married filing a joint return or $2,500 per calendar year if married filing separately).	$_____
3. Enter your total personal exemptions ($2,900 each for you, your spouse and your dependent children in 2002).	$_____
4. Enter the amount of your itemized deduction from your last year's return or, if you do not itemize, subtract $6,650 if you are head of household, $7,600 if you are married filing jointly, or $3,800 if you are married filing separately in 2002.	$_____
5. Add lines 2, 3 and 4 and enter the total here.	$_____
6. Subtract line 5 from line 1. This is your taxable income.	$_____
7. Enter the tax rate decimal value from Chart 2 below for your taxable income as shown on line 6 above.	_____
8. Multiply line 2 (Dependent Care FSA contributions) by line 7 and enter the result here. **This is your estimated income tax savings with the Dependent Care FSA.**	$_____

Chart 2	
Head of Household with Taxable Income	**Tax Rate Decimal Value**
Less than $36,250	.150
Over $36,250 but less than $93,650	.275
Over $93,650 but less than $151,650	.305
Married, Filing Jointly with Taxable Income	**Tax Rate Decimal Value**
Less than $45,200	.150
Over $45,200 but less than $109,250	.275
Over $109,250 but less than $166,500	.305
Married, Filing Separately with Taxable Income	**Tax Rate Decimal Value**
Less than $22,600	.150
Over $22,600 but less than $54,625	.275
Over $54,625 but less than $83,250	.305

Compare the dollar amount on line 4 of Worksheet 1 with the dollar amount on line 8 of Worksheet 2. Generally, whichever amount is larger represents the most income tax savings for you. (As previously explained, however, tax regulations are complex and these worksheets cannot take all individual tax considerations into account. They can only help estimate potential tax savings. For a more precise determination of your tax savings consult a tax advisor.)

Making Changes

The election you make when you enroll is effective for the entire calendar year. You may only change your election — begin, increase, decrease or stop your contributions — during open enrollment, or when you have a qualifying change in status. The following are examples of qualifying changes in status:

- Change in your legal marital status including marriage, divorce, death of a spouse, legal separation or annulment
- Change in the number of your dependents due to birth, adoption or placement for adoption, or death of a dependent
- Ending or starting employment by you, your spouse or dependent
- A reduction or increase in hours by you, your spouse or dependent, including a switch between part-time and full-time status, a strike, lockout or beginning or return from an unpaid leave of absence (including FMLA leave)
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, gain or loss of student status, marriage or any similar circumstances as are provided in the accident or health plan
- Change in the place of residence or work of you, your spouse or dependent
- Significant changes in the health coverage of the employee or spouse attributable to the spouse's employment.

You have 60 days from the date of your change in status to make changes to your FSA election(s). The change you make must be consistent with and on account of your status change. Please contact Benefits & Well-Being if you have questions about changes in status.

Reimbursement

Copy and use the Dependent Care Reimbursement Request Form (pages 17-18) to get reimbursed for dependent care expenses. Attach any appropriate receipts, or have the dependent care provider sign the claim form instead of a receipt. Fax or mail the information to AAI.

If you submit a claim for an amount that is more than your account balance, you will be reimbursed up to the amount you currently have in your account. When future contributions are made to your account, you will automatically receive another reimbursement, until your total claim amount has been reimbursed or you reach your calendar year election amount.

If You Leave Employment

If you leave employment your participation in your Dependent Care FSA ends the day you leave employment. You have until March 31of the following year to submit reimbursement requests for expenses incurred through the date you leave.

✝ FSA Forms

The last five pages of this guide are forms (also available at www.metrokc.gov/ohrm/benefits):

- Health Care Reimbursement Request Form (pages 15-16). Copy and submit this form to AAI to request reimbursements for eligible health care expenses.
- Dependent Care Reimbursement Request Form (pages 17-18). Copy and submit this form to AAI to request reimbursements for eligible dependent care expenses.
- Status Change Form (page 19). Submit this form to Benefits & Well-Being when you have a qualifying change in status and need to change your FSA election.
- Reimbursement Direct Deposit Request Form (page 20). Submit this form with your enrollment form to Benefits & Well-Being to have your FSA reimbursements automatically deposited to your bank account. If already enrolled in an FSA, submit the form to AAI.
- Enrollment Form (page 21). Return this form to Benefits & Well-Being:
  - Within 30 days of your benefit eligibility date if you're a new employee
  - Within 60 days of a qualifying status change if you're an established employee enrolling for the first time (see "Making Changes" sections for examples of qualifying changes in status)
  - By the open enrollment deadline if you wish to enroll or re-enroll for next year (you must re-enroll each year at open enrollment to continue participating in FSAs).

You may fax your enrollment form, but must mail a signed Reimbursement Direct Deposit Request Form to AAI if you want FSA reimbursements automatically direct deposited.

ASSOCIATED ADMINISTRATORS, INC.

King County Health Care FSA Reimbursement Request Form

See reverse side for instructions.

Please complete ALL information in this section.

Participant Name		Soc Sec Number
Mailing Address		
New address? ☐ Yes ☐ No	Home Phone (include Area Code)	Work Phone (include Area Code)

Please list expenses for reimbursement in this section.

1	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
2	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
3	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
4	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
			Total Reimbursement Amount	**$**

I understand the Internal Revenue Code permits Health Care Personal Choice Account®/FSA reimbursements only for most tax deductible medical expenses. I have attached written documentation from a doctor, hospital or other medical service provider for each expense listed above. The documentation shows the expenses were incurred by me or my eligible dependents and includes the date(s) the services were received, the type of services and the total expense. I understand neither AAI nor King County shall be responsible for any taxes, interest, penalties or other consequences which may be assessed or arise as a result of any disallowed expenses.

I request reimbursement for the attached expenses under the Health Care Personal Choice Account®/FSA Plan. I certify that I or my eligible dependents have incurred these services and to the best of my knowledge they are reimbursable under the terms of King County's plan. Furthermore, I certify I have not been reimbursed for these expenses from, nor are these expenses reimbursable by, any other source. These expenses have not been and will not be used to claim any federal income tax deduction.

Plan Participant Signature _____ **Date** _____

AAI has tried to make the administration of your Health Care Personal Choice Account®/FSA as straightforward as possible, but reminds you: 1) you must use this form to request reimbursement and 2) Health Care Personal Choice Account® reimbursement dollars are paid directly to you and may not be assigned to any other person.

Submit your completed form to: **Associated Administrators Inc./Personal Choice Account® Unit**
PO Box 3199 - Mail Station B-20F - Portland OR 97208-3199
Fax 1.800.979.8987 ✍ Phone 1.800.334.4340 ✍ E-mail flex@aai-tpa.com

Health Care Reimbursement Request Form Instructions

Here are some reminders for completing this form. Refer to the FSA Guide for more complete details.

1. The expense must be a health related (medical, dental or vision) expense incurred by you or one of your dependents.
2. The expense must be an expense that would have qualified for a tax deduction under the Internal Revenue Code (excluding health and long term care insurance premiums and long term care expenses).
3. Supporting documentation must accompany this request form. Supporting documentation includes the following:
   - An itemized bill showing dates of service, type of service, provider's name, patient's name and amount of service or
   - Copy of any "Explanation of Benefits" (EOB) statement from any insurance plan under which the claimant is covered if it includes the same information as an itemized bill.
   - **Balance forward statements and checks (copies of initial and/or cancelled checks) are not acceptable.**
4. Complete the Health Care FSA Reimbursement form and submit the original along with your supporting documentation to:

   Associated Administrators, Inc.
   Personal Choice Account® Unit
   PO Box 3199 - Mail Station B-20F
   Portland OR 97208-3199
   Fax 1.800.979.8987

5. Retain a copy of the reimbursement request form and copy(ies) of supporting documents for your records. Copies submitted to AAI will not be returned.
6. All reimbursements will be paid by check (mailed to your home address) or direct deposit (notice of direct deposit mailed to your home).
7. If you have questions, please contact the Personal Choice Account® Unit at 1.800.334.4340 or flex@aai-tpa.com.

ASSOCIATED ADMINISTRATORS, INC.

King County Dependent Care FSA Reimbursement Request Form

See reverse side for instructions.

Please complete ALL information in this section.

Participant Name		Soc Sec Number
Mailing Address		
New address? ☐ Yes ☐ No	Home Phone (include Area Code)	Work Phone (include Area Code)

Please list expenses for reimbursement in this section.

1	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
2	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
3	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
4	Name for Whom Expense Incurred			Relationship to Plan Participant
	Dates of Service	Begin Date	End Date	$ Amount
			Total Reimbursement Amount	**$**

I understand the Internal Revenue Code permits Dependent Care Personal Choice Account®/FSA reimbursements only for certain dependent care expenses. I have attached written documentation from a dependent care provider for each expense listed above. The documentation shows the name of my eligible dependent who received the care, the name, address and taxpayer identification number of the care provider (Social Security number for an individual care provider), the date(s) the care was provided and the amount paid. I understand neither AAI nor King County shall be responsible for any taxes, interest, penalties or other consequences which may be assessed or arise as a result of any disallowed expenses.

I request reimbursement for the attached expenses under the Dependent Care Personal Choice Account®/FSA Plan. I certify that I or my eligible dependents have incurred these services and to the best of my knowledge they are reimbursable under the terms of King County's plan. Furthermore, I certify I have not been reimbursed for these expenses from, nor are these expenses reimbursable by, any other source. These expenses have not been and will not be used to claim any Federal Child Care Tax Credit.

Plan Participant Signature _____ **Date** _____

AAI has tried to make the administration of your Dependent Care Personal Choice Account®/FSA as straightforward as possible, but reminds you: 1) you must use this form to request reimbursement and 2) Dependent Care Personal Choice Account® reimbursement dollars are paid directly to you and may not be assigned to any other person.

Submit your completed form to: **Associated Administrators Inc./Personal Choice Account® Unit**
PO Box 3199 - Mail Station B-20F - Portland OR 97208-3199
Fax 1.800.979.8987 ✍Phone 1.800.334.4340 ✍E-mail flex@aai-tpa.com

Dependent Care Reimbursement Request Form Instructions

Here are some reminders for completing this form. Refer to the FSA Guide for more complete details.

1. Dependent Care expenses are those services that are rendered for the care of a qualifying individual to enable you and your spouse (if applicable) to be gainfully employed. A qualifying individual is:
   - Your dependent(s) under 13 years of age if you are entitled to a personal exemption for the dependent, or
   - A dependent or spouse who is physically or mentally incapable of caring for themselves.
   - A dependent who regularly spends at least eight (8) hours each day in your home.
2. Examples of covered dependent care expenses are listed below:
   - Services outside of your home such as a child care center, babysitter or nurse for your dependents under the age of 13 or for an incapacitated dependent or spouse.
   - Expenses of caring for a qualified individual inside your home.
3. Examples of non-covered dependent care services:
   - Educational services from kindergarten on.
   - Overnight camps.
4. Qualifying dependent care assistance can be provided by a relative as long as the relative is not one for whom you can take a personal exemption as a dependent, your spouse or child under the age of 19.
5. Supporting documentation must accompany this request form. Supporting documentation includes bills, receipts or other evidence providing dates of service and the name, address and taxpayer identification number of the dependent care service provider. **Balance forward statements and checks (copies of initial and/or cancelled checks) are not acceptable.**
6. Complete the Dependent Care FSA Reimbursement Request Form and submit original along with your supporting documentation to:

   Associated Administrators, Inc.
   Personal Choice Account® Unit
   PO Box 3199 - Mail Station B-20F
   Portland OR 97208-3199
   Fax 1.800.979.8987

7. Retain a copy of the reimbursement request form and copy(ies) of supporting documents for your records. Copies submitted to AAI will not be returned.
8. All reimbursements will be paid by check (mailed to your home address) or direct deposit (notice of direct deposit mailed to your home).
9. If you have questions, please contact the Personal Choice Account® Unit at 1.800.334.4340 or flex@aai-tpa.com.

ASSOCIATED ADMINISTRATORS, INC.

King County FSA Status Change Form

Participant Information

Employee Name _____

Social Security Number _____

Type of Change (Check appropriate boxes and complete related sections.)

☐ Qualified Status Change
☐ Name Change
☐ Work Phone Number Change
☐ Address Change

Personal Information Change

Name Change _____ (Old Name) to _____ (New Name)

New Address _____
Street/PO Box Apt. # City State ZIP

New Work Phone Number _____
Area Code Phone Number

Qualified Status Change*

Describe type of change _____
Birth, Adoption, Marriage, Unpaid Leave of Absence, Etc.

From $ _____/Pay Period To $ _____/Pay Period **Health Care FSA**

From $ _____/Pay Period To $ _____/Pay Period **Dependent Care FSA**

From $ _____/Pay Period To $ _____/Pay Period **Group Insurance Premiums**

Effective Date of Change _____

*** Consistency Rule: IRS rules allow revocation of plan coverage and a new election for the remaining portion of the calendar year only if the election change is consistent with the status change.**

Authorization

Employee Signature _____ Date _____

Employer Authorization _____ Date _____

Submit your completed form to : **King County Benefits & Well-Being**
Yesler Building YES-HR-0500
400 Yesler Way, Seattle WA 98104-2683
Fax 206.684.1925 ✍ Phone 206.684.1556 ✍ E-mail kc.benefits@metrokc.gov

ASSOCIATED ADMINISTRATORS, INC.

King County FSA Reimbursement Direct Deposit Request Form

Associated Administrators, Inc.
1.800.334.4340
E-mail flex@aai-tpa.com

PO Box 3199
Mail Station B-20F
Portland OR 97208-3199

King County Benefits & Well-Being
206.684.1556
E-mail kc.benefits@metrokc.gov

Yesler Building YES-HR-0500
400 Yesler Way
Seattle WA 98104-2683

Authorization for Reimbursement Direct Deposit

Name		Social Security Number
Street or PO Box		Daytime Phone
City	State	ZIP

Depository Information

Financial Institution		
Account Number	Branch	
City	State	ZIP
Type of Account ☐ Checking ☐ Savings		

I wish to have my health care and/or dependent care reimbursements deposited directly to my checking or savings account designated above. I hereby authorize Associated Administrators, Inc. (AAI) to originate an electronic credit transaction to my bank or credit union account as indicated above and to credit the same to such account. If necessary, AAI may make deductions from my account for any payments credited to my account in error. This authority is to remain in full force and effect until the end of the current calendar year or my participation in King County's plan terminates and AAI is afforded a reasonable opportunity to act on it.

Signature _____ **Date Signed** _____

Note: Due to Automated Clearing House (ACH) procedures for initiating automatic deposits, the deposit does not occur until all testing of accounts is completed.

For direct deposit verification attach a:

- ? **VOIDED CHECK** for automatic deposit to your checking account
- ? **SAVINGS ACCOUNT DEPOSIT SLIP** for automatic deposit to your savings account.

Return this form (do not fax) to:

- ? **KING COUNTY BENEFITS & WELL-BEING** with your enrollment form if you're enrolling in an FSA for the first time
- ? **AAI** if you're already enrolled in an FSA but are authorizing direct deposit for the first time or changing previously authorized direct deposit.

King County Flexible Spending Account Enrollment Form

Complete this form to enroll in a Health Care FSA, Dependent Care FSA or both. Complete the back if you want FSA reimbursements direct deposited. Return forms to Benefits & Well-Being, Yesler Building YES-HR-0500, 400 Yesler Way, Seattle WA 98104-2683:

? **Within 30 days of your benefit eligibility date** if you're a new employee
? **Within 60 days of a qualifying status change** if you're an established employee enrolling for the first time
? **By the open enrollment deadline** if you wish to enroll or re-enroll for next year -- annual enrollment is required.

✍Participant

Printed Name _____ Soc Sec No _____

Street Address or PO Box _____

City _____ State _____ ZIP _____

E-mail _____ Contact Phone(_____)_____

Paid ☐ 5th & 20th each month ☐ Every other Thursday

Effective ☐ When I'm eligible (mo/yr) _____ *or* ☐ My annual re-enrollment (yr) _____

Eligibility date verified by Benefits & Well-Being. Effective date indicated at bottom of form.

✍Health Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The maximum you may contribute may not exceed $3,000 annually. Whether you're paid 24 or 26 times per year, a maximum of 24 payroll deductions will be taken. The per paycheck deduction amount is determined by the date your enrollment is processed and made effective.

☐ Yes, I elect to participate. Please deduct a total of $ _____ from my paychecks for the year 20 _____.

✍Dependent Care FSA

Please check yes if you elect to participate and indicate the total amount you'd like deducted for the year. The maximum you may contribute may not exceed: 1) the lower of husband's or wife's earned income, 2) $5,000 annually if married filing jointly or head of household or 3) $2,500 annually if married filing separately. Whether you're paid 24 or 26 times per year, a maximum of 24 payroll deductions will be taken. The per paycheck deduction amount is determined by when your enrollment is processed and made effective.

☐ Yes, I elect to participate. Please deduct a total of $ _____ from my paychecks for the year 20 _____.

✍Authorization

I authorize King County to withhold a portion of my pre-tax employment compensation and deposit these funds to the FSA(s) I've designated above. In consideration of King County allowing me to participate in the plan, I agree to abide by the terms, conditions and provisions of the plan contained in the county's plan document. I have been informed the plan may be modified from time to time and I agree King County may cancel or amend the plan according to its independent judgment and discretion. I understand I will be notified in advance of any changes. I acknowledge my right to examine the plan document or obtain a copy of it by giving reasonable advance notice to the plan administrator and paying a reasonable copy cost.

I acknowledge the Internal Revenue Code and the plan permit me to claim reimbursement only for my eligible expenses incurred after the effective date of my FSA elections. I understand the Internal Revenue Code prohibits me from claiming the Federal Child Care Tax Credit for dependent care assistance expenses which are reimbursed to me by the plan. I assume full responsibility for all taxes, penalties, interest or other consequences, which may be assessed to or imposed on me by any state, federal or other governmental taxing authority as a result of my requesting and receiving reimbursements from the plan for disallowed expenses.

I choose to participate in the FSA Program despite my knowledge my salary reduction elections may reduce my FICA withholdings (Social Security) and this may reduce my Social Security benefits upon retirement.

I understand I must claim reimbursement for eligible expenses incurred during the calendar year on or before 90 days after the last day of the calendar year or I will forfeit those reimbursements. I further acknowledge I will forfeit all funds credited to my FSAs, which are not reimbursed to me.

I understand the total amount I have requested will be deducted for the year I have indicated, but my per paycheck deduction amount will be determined by when my enrollment is processed and made effective.

Signature _____ **Date Signed** _____

Office Use Only	Received Date Staff Name	Eligibility Verified Date Staff Name	Copy to B&WB File Date Staff Name	Copy to AAI Date Staff Name	FSA Effective Date